		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037556

Facility Name: Columbia Convalescent Center

Address: 253 Bradington Dr. (Number) Columbia (City) 62236 (Zip Code)

County: Monroe

Telephone Number: 618-281-6800 **Fax #** 618-281-6557

IDPA ID Number: 37-1280633001

Date of Initial License for Current Owners: 11/01/1991

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David Wendler **Telephone Number:** 618-281-6800

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Steven C. Wolf
(Title) Owner

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	119	Skilled (SNF)	119	43,554	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,554	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		2,588	1,281	3,869	8
9	SNF/PED					9
10	ICF	15,254	17,040		32,294	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,254	19,628	1,281	36,163	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.03%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/1/1991

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,281

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Columbia Convalescent Center # 0037556 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	206,157	8,918	7,401	222,476		222,476	(2,511)	219,965			1
2	Food Purchase		157,355		157,355		157,355		157,355			2
3	Housekeeping	155,820	18,724		174,544		174,544		174,544			3
4	Laundry	64,552	17,313	14,167	96,032		96,032		96,032			4
5	Heat and Other Utilities			125,955	125,955		125,955		125,955			5
6	Maintenance	54,117	20,556	40,663	115,336		115,336		115,336			6
7	Other (specify):*											7
8	**TOTAL General Services**	480,646	222,866	188,186	891,698		891,698	(2,511)	889,187			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,690,583	34,786	30,379	1,755,748	14,114	1,769,862		1,769,862			10
10a	Therapy			113,703	113,703	(14,114)	99,589		99,589			10a
11	Activities	73,675	8,842		82,517		82,517		82,517			11
12	Social Services	46,160	103	1,237	47,500		47,500		47,500			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,810,418	43,731	154,319	2,008,468		2,008,468		2,008,468			16
	C. General Administration											
17	Administrative	91,033		158,860	249,893		249,893		249,893			17
18	Directors Fees											18
19	Professional Services			17,498	17,498	2,800	20,298		20,298			19
20	Dues, Fees, Subscriptions & Promotions			15,006	15,006		15,006	(2,925)	12,081			20
21	Clerical & General Office Expenses	131,437	9,617	39,681	180,735	(2,800)	177,935		177,935			21
22	Employee Benefits & Payroll Taxes			427,944	427,944		427,944		427,944			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,081	2,081		2,081	(18)	2,063			24
25	Other Admin. Staff Transportation			1,987	1,987		1,987		1,987			25
26	Insurance-Prop.Liab.Malpractice			197,555	197,555		197,555	(20,987)	176,568			26
27	Other (specify):* Cable TV/Contrib			7,064	7,064		7,064	(7,064)				27
28	**TOTAL General Administration**	222,470	9,617	867,676	1,099,763		1,099,763	(30,994)	1,068,769			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,513,534	276,214	1,210,181	3,999,929		3,999,929	(33,505)	3,966,424			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Columbia Convalescent Center #0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			160,151	160,151		160,151		160,151			30
31	Amortization of Pre-Op. & Org.			2,760	2,760		2,760		2,760			31
32	Interest			109,743	109,743		109,743	(501)	109,242			32
33	Real Estate Taxes			86,334	86,334		86,334		86,334			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,045	5,045		5,045		5,045			35
36	Other (specify):*											36
37	**TOTAL Ownership**			364,033	364,033		364,033	(501)	363,532			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,456	2,595	31,051		31,051		31,051			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		4,670		4,670		4,670		4,670			41
42	Provider Participation Fee			65,331	65,331		65,331		65,331			42
43	Other (specify):* **Income taxes**			9,459	9,459		9,459		9,459			43
44	**TOTAL Special Cost Centers**		33,126	77,385	110,511		110,511		110,511			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,513,534	309,340	1,651,599	4,474,473		4,474,473	(34,006)	4,440,467			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,511)	1		4
5	Telephone, TV & Radio in Resident Rooms	(5,390)	27		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(501)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(18)	24		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,674)	27		20
21	Owner or Key-Man Insurance	(20,987)	26		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,925)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,006)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (34,006)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Columbia Convalescent Center

ID# 0037556

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Columbia Convalescent Center # 0037556 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(2,511)	0	0	0	0	0	0	0	0	0	0	(2,511)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,511)	0	0	0	0	0	0	0	0	0	0	(2,511)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(2,925)	0	0	0	0	0	0	0	0	0	0	(2,925)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(18)	0	0	0	0	0	0	0	0	0	0	(18)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(20,987)	0	0	0	0	0	0	0	0	0	0	(20,987)	26
27	Other (specify):*	(7,064)	0	0	0	0	0	0	0	0	0	0	(7,064)	27
28	**TOTAL General Administration**	(30,994)	0	0	0	0	0	0	0	0	0	0	(30,994)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(33,505)	0	0	0	0	0	0	0	0	0	0	(33,505)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Columbia Convalescent Center # 0037556 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(501)	0	0	0	0	0	0	0	0	0	0	(501)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(501)	0	0	0	0	0	0	0	0	0	0	(501)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(34,006)	0	0	0	0	0	0	0	0	0	0	(34,006)	45

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Wolf	50.00%	Eldercare of Alton/Calvin Johnson Care Center	Belleville/Alton	Eldercare/SAMAS	Belleville	Mgmt Co.
Michael Riley	16.00%	Collinsville Care Center	Collinsville	SAMAS	Belleville	Mgmt Co.
Minority Shareholders	34.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 158,860	SAMAS PARTNERSHIP	0.00%	$ 158,860	$	1
2	V	17	Administrator Bonus	7,000	SAMAS PARTNERSHIP	0.00%	7,000		2
3	V	21	Bank Charges	255	SAMAS PARTNERSHIP	0.00%	255		3
4	V	19	Accounting Fees	360	SAMAS PARTNERSHIP	0.00%	360		4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 166,475			$ 166,475	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Steve Wolf	President	Owner/Admin	50.00	A	10	14.00	Mgmt fees	$ 84,650	17-3	1
2	Michael Riley	Secretary	Owner/Admin	16.00	0	20	30.00	Mgmt fees	44,257	17-3	2
3	Steven Brant	Treasurer	Owner/Admin	4.00	B	10	17.00	Mgmt fees	29,953	17-3	3
4											4
5											5
6		A- Eldercare, Inc.	169929								6
7											7
8		B- Four Fountains	45426								8
9											9
10											10
11											11
12											12
13								TOTAL	$ 158,860		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Union Planters		X	Mortgage Original	$21,665.39	3/6/02	$ 2,740,484	$			$ 66,869	1
2	Union Planters		X	Mortgage New Addition	$7,518.65	3/6/02	925,720					2
3	Union Planters		X	Mortgage New Addition	$2,618.34	3/6/02	300,000					3
4	Peoples National Bank		X	Mortgage Refinace	$20,608.61	8/11/04	2,800,000	2,714,292	08/11/2019	variable	42,649	4
5												5
	Working Capital											
6	Peoples National Bank		X	Working Capital	interest only	8/11/04	500,000	104,000	8/11/05	variable	225	6
7												7
8												8
9	TOTAL Facility Related				$52,410.99		$ 7,266,204	$ 2,818,292			$ 109,743	9
	B. Non-Facility Related*											
10								Int Income			(501)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (501)	14
15	TOTALS (line 9+line14)						$ 7,266,204	$ 2,818,292			$ 109,242	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	77,278	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	82,368	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,090	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	81,243	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	86,333	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	78,005	8
	2000	80,068	9
	2001	77,744	10
	2002	77,278	11
	2003	82,368	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Columbia Convalescent Center COUNTY Monroe

FACILITY IDPH LICENSE NUMBER 0037556

CONTACT PERSON REGARDING THIS REPORT David Wendler

TELEPHONE 618-281-6800 FAX #: 618-281-6557

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-17-481-028-000	Lot 2 & Pt Lot 1 Bradington Pl	$ 21,768.00	$ 21,768.00
2.	04-17-481-005-000	Part Lot 4 Sur 416	$ 686.00	$ 686.00
3.	04-17-481-004-000	Part Lot 4 Sur 416	$ 59,914.00	$ 59,914.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 82,368.00	$ 82,368.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,079 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	189,566	1991	$ 249,469	1
2	Resident Care	21,364	1993	28,115	2
3	TOTALS	210,930		$ 277,584	3

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1991	1991	$ 2,115,587	$ 52,890	40	$ 52,890	$	$ 740,456	4
5			1991	1991	48,503	3,234	40	3,234		42,036	5
6	20		1998	1998	1,170,228	29,256	40	29,256		187,724	6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1991	147,905	7,395	20	7,395		96,754	9
10	Fixed Equipment			1991	24,679	1,645	18	1,645		21,387	10
11	Alarm System			1992	910	61	15	61		789	11
12	Water Softner			1992	8,625	575	12	575		6,900	12
13	Carpet			1993	1,430		12			1,430	13
14	Guttering			1994	899		8			870	14
15	Pavillion			1994	7,400	617	12	617		6,475	15
16	Misc Improvements			1995	2,165		10			2,121	16
17	Drainage System			1996	1,374	92	15	92		748	17
18	Cold Water Line			1996	6,803	174	39	174		1,512	18
19	A/C Compressor			1996	1,574		7			1,574	19
20	Carpet			1996	591		7			591	20
21	Hot Water Heater			1996	3,473		7			3,473	21
22	Heat Trace & Hot Water Pipes			1996	1,535	102	15	102		810	22
23	Furnace and Air conditioning renovation			1997	1,690	169	10	169		1,282	23
24	Day Room Carpet and Window Treatments			1997	7,658	452	7	452		7,658	24
25	Telephone/Voice Mail System			1997	14,739		5			14,739	25
26	Entry Area Carpeting			1997	1,080	103	7	103		1,080	26
27	UPS Battery Back-up System			1997	733		5			733	27
28	Door			1997	1,485	38	39	38		272	28
29	Fan			1997	1,083	28	39	28		199	29
30	Landscaping			1998	4,030	269	15	269		1,653	30
31	Landscaping			1998	7,429	495	15	495		3,178	31
32	Irrigation System			1998	12,990	866	15	866		5,557	32
33	Parking Lot			1998	15,912	1,061	15	1,061		6,807	33
34	Landscaping			1998	10,479	699	15	699		4,483	34
35	Sidewalks			1998	19,864	1,324	15	1,324		8,498	35
36	Draperies & Window Treatments			1998	18,417		5			18,417	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Flooring & Carpeting	1998	$ 36,840	$ 3,684	10	$ 3,684	$	$ 23,603	37
38	Decorating Wallpapering & Painting	1998	49,156	58	5	58		48,946	38
39	Alarm Security System	1998	17,574	1,733	5-7y	1,733		15,423	39
40	Attic Ventilating Fans	1998	6,179	618	10	618		4,119	40
41	Storeroom Locks	1998	593	85	7	85		516	41
42	Telephone Equipment	1998	1,940	194	10	194		1,277	42
43	Light Fixtures	1998	4,291	429	10	429		2,754	43
44	Therapy Room Sink	1998	1,213	173	7	173		1,053	44
45	Signage	1998	116	12	10	12		75	45
46	Site Lighting	1998	5,684	812	7	812		5,210	46
47	Landscaping	1999	6,955	464	15	464		2,501	47
48	Water Heater Replacement	1999	35,258	3,526	10	3,526		19,513	48
49	Washer & Dryer	1999	4,600	460	10	460		2,338	49
50	Air Conditionner	1999	8,965	896	10	896		4,629	50
51	Room Renovations	1999	6,778	461	5-10y	461		4,824	51
52	Door Security System	1999	14,347	1,435	10	1,435		7,750	52
53	Landscaping	2000	1,987	132	15	132		573	53
54	Water Heater Replacement	2000	6,848	685	10	685		3,367	54
55	Carpeting	2000	1,579	158	10	158		711	55
56	Floor Tile	2001	1,546	155	10	155		606	56
57	Landscaping	2001	2,127	142	10	142		512	57
58	Evaporator Coil	2001	2,514	251	10	251		901	58
59	Vinal Trim Window	2001	6,459	646	10	646		2,045	59
60	Painting	2001	6,080	608	10	608		1,875	60
61	Telephone System	2001	1,631	326	10	326		1,006	61
62	Alert System	2001	6,443	920	7	920		2,530	62
63	Alert System	2002	6,442	921	7	921		2,532	63
64	Landscaping	2002	417	28	15	28		77	64
65	Heating Cooling	2002	7,477	748	10	748		1,933	65
66	Carpeting, fire doors, electrical	2002	4,968	497	10	497		1,179	66
67	Parking Lot	2003	3,420	228	15	228		247	67
68	Hot Water Heater	2002	2,380	238	10	238		694	68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,924,076	$ 123,268		$ 123,268	$	$ 1,355,525	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,924,076	$ 123,268		$ 123,268	$	$ 1,355,525	1
2									2
3	Bathroom impr	2003	624	62	10	62		78	3
4	Air Conditioning/temp control	2003	3,604	360	10	360		450	4
5	Nurse Call System	2003	1,075	107	10	107		125	5
6	Hot water system	2003	5,603	560	10	560		934	6
7	Payroll wiring/ time system	2003	2,000	200	10	200		367	7
8	Valves,adapters, coils A/C	2003	3,626	363	10	363		600	8
9	Security upgrades	2003	522	52	10	52		83	9
10	Control joints	2003	1,019	102	10	102		170	10
11	Parking lot sealer/striping	2004	300	18	15	18		18	11
12	Guard rails, concrete work docking area	2004	17,387	56	15	56		56	12
13	New Lighting	2004	21,784	1,218	10	1,218		1,218	13
14	Painting	2004	2,115	85	10	85		85	14
15	Air Conditioning/Hot water system	2004	8,069	712	10	712		712	15
16	Wiring call system, security system	2004	2,917	211	10	211		211	16
17	Flooring	2004	1,777	74	10	74		74	17
18	Kitchen Hood, grill	2004	2,871	38	10	38		38	18
19	Fire dampers	2004	2,600		10				19
20	Generator tank	2004	3,632	303	10	303		303	20
21	Plumbing	2004	974	81	10	81		81	21
22	Ventilation Laundry dept	2004	15,505	904	10	904		904	22
23	Thermocouplers	2004	1,208	111	10	111		111	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,023,288	$ 128,885		$ 128,885	$	$ 1,362,143	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 282,905	$ 30,560	$ 30,560	$	5-10 yr	$ 161,951	71
72	Current Year Purchases	14,515	706	706			706	72
73	Fully Depreciated Assets	403,230					403,230	73
74								74
75	TOTALS	$ 700,650	$ 31,266	$ 31,266	$		$ 565,887	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1994 Ford Van	1993	$ 38,214	$	$	$	5	$ 38,214	76
77										77
78										78
79										79
80	TOTALS			$ 38,214	$	$	$		$ 38,214	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,039,736	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 160,151	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 160,151	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,966,244	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 5,045 Description: Office-924 Nursing- 3169 dietary- 952
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10-A-3	hrs	$	695	$ 41,320	$ 130	695	$ 41,450	1
2	Licensed Speech and Language Development Therapist	10-A-3	hrs		89	7,885	25	89	7,910	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-A-3	hrs		809	49,892	337	809	50,229	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				28,546		28,546	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab/X-Ray	39-3				2,595			2,595	13
14	TOTAL			$	1,593	$ 101,692	$ 29,038	1,593	$ 130,730	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Columbia Convalescent Center # 0037556 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 66,970	$	1
2	Cash-Patient Deposits	6,952		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	509,408		3
4	Supply Inventory (priced at cost)	22,058		4
5	Short-Term Investments			5
6	Prepaid Insurance	70,926		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Mgmt Co	38,525		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 714,839	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	277,583		13
14	Buildings, at Historical Cost	4,025,297		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	736,854		16
17	Accumulated Depreciation (book methods)	(1,966,243)		17
18	Deferred Charges	6,191		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Constr period Int-Net	22,911		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,102,593	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,817,432	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 189,031	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,952		28
29	Short-Term Notes Payable	220,684		29
30	Accrued Salaries Payable	120,084		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,486		31
32	Accrued Real Estate Taxes(Sch.IX-B)	81,243		32
33	Accrued Interest Payable	8,771		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 633,251	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,597,608		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,597,608	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,230,859	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 586,573	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,817,432	$	48

***(See instructions.)**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 682,802	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 682,802	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	343,769	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(440,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	2	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (96,229)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 586,573	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,586,350	1
2	Discounts and Allowances for all Levels	(39,706)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,546,644	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	166,351	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 166,351	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	8,544	12
13	Barber and Beauty Care	7,200	13
14	Non-Patient Meals	2,511	14
15	Telephone, Television and Radio	2,774	15
16	Rental of Facility Space		16
17	Sale of Drugs	64,276	17
18	Sale of Supplies to Non-Patients	6,689	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	11,793	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 103,787	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	501	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 501	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc	959	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 959	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,818,242	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	891,698	31
32	Health Care	2,008,468	32
33	General Administration	1,099,763	33
	B. Capital Expense		
34	Ownership	364,033	34
	C. Ancillary Expense		
35	Special Cost Centers	45,180	35
36	Provider Participation Fee	65,331	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,474,473	40
41	**Income before Income Taxes (line 30 minus line 40)****	343,769	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 343,769	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

Cash Basis Return

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,892	2,120	$ 76,568	$ 36.12	1
2	Assistant Director of Nursing	1,382	1,515	37,824	24.97	2
3	Registered Nurses	7,135	7,819	193,046	24.69	3
4	Licensed Practical Nurses	20,868	22,573	433,480	19.20	4
5	Nurse Aides & Orderlies	72,057	77,156	897,629	11.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,261	4,726	52,036	11.01	8
9	Activity Director	1,939	2,101	27,811	13.24	9
10	Activity Assistants	5,538	5,899	45,864	7.77	10
11	Social Service Workers	2,645	2,974	46,160	15.52	11
12	Dietician					12
13	Food Service Supervisor	1,993	2,202	29,210	13.27	13
14	Head Cook	4,644	5,113	67,061	13.12	14
15	Cook Helpers/Assistants	13,796	14,761	109,886	7.44	15
16	Dishwashers					16
17	Maintenance Workers	3,923	4,215	54,117	12.84	17
18	Housekeepers	16,566	17,874	155,820	8.72	18
19	Laundry	6,581	6,963	64,552	9.27	19
20	Administrator	1,883	2,125	91,033	42.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,879	9,866	131,437	13.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,982	190,002	$ 2,513,534 *	$ 13.23	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	102	$ 5,120	1-3	35
36	Medical Director	varies	9,000	9-3	36
37	Medical Records Consultant	14	540	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	720	10-3	39
40	Physical Therapy Consultant	187	11,619	10	40
41	Occupational Therapy Consultant	36	2,366	10	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	129	10	43
44	Activity Consultant				44
45	Social Service Consultant	35	1,238	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	400	$ 30,732		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	32	$ 1,069	10-3	50
51	Licensed Practical Nurses	265	8,068	10-3	51
52	Nurse Aides	969	17,803	10-3	52
53	TOTAL (lines 50 - 52)	1,266	$ 26,940		53

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
David Wendler	Administrator	0	$ 91,033
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,033

B. Administrative - Other

Description	Amount
Management fees to SAMAS	$ 158,860
TOTAL (agree to Schedule V, line 17, col. 3)	$ 158,860
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
J.W. Boyle	Accounting	$ 11,720
Wessel & Pautch	Legal	120
Flynn & Guymon	Legal	1,837
Duane Morris	Legal	3,164
Moore Renner & Simonin	Accounting	657
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 17,498

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,423
Unemployment Compensation Insurance	27,471
FICA Taxes	186,010
Employee Health Insurance	98,668
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 K	2,408
Scholorships	1,235
Employee relations	11,729
TOTAL (agree to Schedule V, line 22, col.8)	$ 427,944

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
	N/A	
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,508
Advertising: Employee Recruitment	3,363
Health Care Worker Background Check	724
(Indicate # of checks performed 60)	
IHCA	5,355
Admin License	100
CLIA Lab fee	150
Group Purchasing	52
Surety Bond	100
Various dues & subs	729
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,081

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,063
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,063

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Columbia Convalescent Center # 0037556 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8							N/A						
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Columbia Convalescent Center **#** 0037556 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA 5355**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-15 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,331**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.